MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-013278 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. Registrar's No. 2937

FILED MAR 21 1963

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED | BY AFFIDAVIT OF

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75

D.E. Cozart

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST.LOUIS,MO
Length of stay in 1b: 10 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST.LOUIS CITY HOSP. #1 — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO. b. COUNTY
c. CITY OR TOWN: ST.LOUIS — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 1404 PAPIN — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First BERDIE Middle Last FULLINGTON
4. DATE OF DEATH: Month, Day, Year: FEB.19,1963
5. SEX: FEMALE
6. COLOR OR RACE: NEGRO
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 2/2/85
9. AGE (last birthday): 78
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown
10b. KIND OF BUSINESS OR INDUSTRY: unknown
11. BIRTHPLACE (City and state or country): Unknown ?
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: ROBERT
13b. MOTHER'S MAIDEN NAME: LIZZIE
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of servi): ? no — NONE
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: ST.LOUIS CITY HOSP. #1.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c): 420.0
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Pneumonia

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 2/14/63 to 2/19/63 and last saw her him alive on 2/19/63
Death occurred at 10:20 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): D. E. Cozart M.D.
22b. ADDRESS: 1515 LAFAYETTE AVE
22c. DATE SIGNED: 2/19/63

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 3/14/63
23c. NAME OF CEMETERY OR CREMATORY: Father Dickson
23d. LOCATION (City, town, or county) (State): St.Louis Co. Mo.

24. FUNERAL DIRECTOR ADDRESS: Anderson 4481 Finney ave.
25. DATE RECD. BY LOCAL REG.: MAR 13 1963
26. REGISTRAR'S SIGNATURE: Karl Smith. M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No._____ working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed John T. Cummings Jr.

Licensed Embalmer No. 4576

P. O. Address 2405 Marcus

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.